State of Tennessee
BOARD OF PROBATION AND PAROLE
FIELD SERVICES DIVISION

Release of Information

Consent and authorization to release information or psychological/medical records under the protection of federal law Title 42, CFR Chapter II, part II.

BIRTHDATE:_____/_____/_____

OFFENDER NAME:_____**SEX:**_____
PRINT FIRST MIDDLE LAST

PARENT/CONSERVATOR:_____
PRINT FIRST MIDDLE LAST

SOCIAL SECURITY NUMBER: _____ **TOMIS NUMBER:** _____

Pursuant to federal guidelines concerning my right to confidentiality,

I _____,
PRINT OFFENDER NAME CLEARLY

hereby give my consent to obtain and exchange confidential medical, psychological, drug and alcohol treatment, mental health, psychiatric evaluation/assessment, discharge/continued care plan, employment verification, and other treatment and educational information or other information as may be necessary, including, but not limited to, computer data, with my Physician, Psychologist, Psychiatrist, Counselor, Social Worker, Probation/Parole Officer or School Officials or other necessary persons.

I understand that this information will be used by the involved agencies to provide necessary services and treatment until the expiration of my sentence.

Information disclosed shall include dates of treatment, treatment recommendations, treatment compliance, and agency contact person.

I understand that I may revoke this "consent to release information" at any time. However, I also understand that any release which has been made prior to my revoking this consent and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization to release information shall expire upon the specific date and expiration of sentence, entered below:

EXPIRATION OF SENTENCE DATE:_____

I have read or had read to me the above statement and understand its contents.

_____ _____
SIGNATURE OF OFFENDER DATE OF SIGNATURE

_____ _____
SIGNATURE OF WITNESS DATE OF SIGNATURE